Randolph Pediatrics

Patient Registration

Patient Name: _____ DOB: _____ Sex: M / F

Mother's Name: _____ DOB: _____

Address: _____ Email: _____
(Street) (City/Zip)

Home#: _____ Cell#: _____ Work: _____

Father's Name: _____ DOB: _____

Address: _____ Email: _____
(Street) (City/Zip)

Home#: _____ Cell#: _____Work: _____

Please list any Allergies, Medications or Medical Conditions:

_____

Please list siblings.

Name	DOB
_____	_____
_____	_____
_____	_____

Guardian (if different from above)

Name/Address: _____

Phone #: _____

Insurance

Carrier: _____ Member ID: _____

Group #: _____ Name of Subscriber: _____

Party responsible for payments: _____

We do not submit to Secondary Insurance. This is the responsibility of parent/guardian

Whom may we thank for referring you to our office? _____

Marisa Ciufalo, MD • 711 Route 10 E • Randolph • NJ • 07869
973-328-9200

Randolph Pediatrics

Financial Policy

Patient Name: _____ DOB: _____

We are committed to providing the best possible care for our patients. Your clear understanding of our financial policy is important to our professional relationship.

The benefit packages provided by insurance companies vary employer to employer. Medical insurance is a contract between you, your employer, and your insurance company. Not all services are a covered benefit in all contracts. You need to learn the benefits of your policy and follow the rules of your policy.

The accompanying parent or adult is responsible for all copays and balances due at the time of service and must have the proper insurance card. Our office will not get involved in divorce settlements. The parent bringing in the patient is financially responsible.

Broken appointments are a cost to us, to you, and other patients who could have used the time set aside for your appointment. Please call us at least 24 hours in advance to make scheduling changes. We reserve the right to charge a $50.00 fee to your account if we find that you continue to miss appointments without advance notice. Excessive missed appointments may result in being discharged from our practice.

If you are experiencing financial difficulty, please let us know. We will make payment plan arrangements.

As stated above, all copays are due at the time of service. Any patient balances are due within thirty days to avoid a late fee of $5.00. Any balances remaining unpaid after ninety days will automatically be sent to collections. In the event this account needs to be placed with an attorney or collection agency because of an unpaid balance, the undersigned agrees and promises to pay a collection fee of $100.00 or 25% of the total balance due, whichever is greater, upon placement with an attorney or collection agency because of unpaid balance remaining on their account.

I have read and understand the financial policy at Randolph Pediatrics.

Parent/Guardian Signature: _____ Date: _____

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Randolph Pediatrics

AUTHORIZATION

Patient Name: _____ DOB: _____

Parent/guardian, please initial each statement and sign after you have read and agreed with the following:

_____ **AUTHORIZATION** I hereby authorize Dr. Ciufalo to give my child reasonable and proper medical care by today's standards and release medical information for any kind of treatment or payment operations by the office staff of Randolph Pediatrics.

_____ **HIPPA** I understand the purpose of the Health Insurance Portability and Accountability Act (HIPPA) that became effective April 14, 2003 and acknowledge that a copy of HIPPA is posted in the office and available to me.

_____ **ASSIGNMENT OF INSURANCE BENEFITS** I authorize release of any medical information necessary to process this claim for the patient(s) above and authorize the payment of medical benefits to the named provider for professional services rendered.

_____ **OFFICE POLICIES AND PROCEDURES** I am aware of office policies and procedures and fees that are clearly posted at the front desk. I understand that these policies, procedures, and fees may be periodically updated but will be clearly posted. I agree that I am financially responsible for all office fees and legal fees incurred on my family's account.

_____ **VACCINATIONS** I agree to go to www.cdc.gov or www.immunize.org for vaccination information and understand that I may ask questions prior to vaccination(s) being administered. Copies of Vaccination Information Sheets are available in office.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Print _____

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BILLING POLICIES*

Thank you for choosing Randolph Pediatrics for your child(ren's) healthcare needs.

We are committed to providing you with exceptional care, as well as making our billing process as efficient as possible. Randolph Pediatrics requests that all patients keep an active credit card on file. Your card information will be kept confidential and secure.

- Complete the below credit card authorization and return the form to the office via mail or the patient portal.
- Please indicate if this is an HSA account card.
- Balances under $50 will automatically be charged to the credit card on file.
- For balances over $50.00, please indicate below the max allowed to charge.

Name of Patient(s)_____

Visa or Mastercard

Name on Card: _____

Card Number: _____ Expiration Date: _____

MAX ALLOWED OVER $50.00 $_____

HSA CARD: YES___ NO___

I, the undersigned, authorize and request Randolph Pediatrics to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Randolph Pediatrics in writing and the account mut be in good standing.

Card Holder's Signature_____Date_____

Your insurance will be billed for all visits, and upon determination of benefits, all patient responsibilities will be subject to billing. All co-pays and outstanding balances require payment at the time of service.
Overdue balances requiring a second mailed statement will incur a $5.00 administrative fee. Missed or canceled appointments, without 24-hour notice, will be subject to a fee of $50.00.

*Billing Policies are subject to change.

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BILLING POLICIES*

Thank you for choosing Randolph Pediatrics for your child(ren's) healthcare needs.

We are committed to providing you with exceptional care, as well as making our insurance billing process as efficient as possible. Your insurance will be billed first for all visits, and upon determination of benefits any patient responsibilities will be subject to billing. Additionally, any missed or cancelled appointments (without 24-hour notice) will be subject to a fee of $50.00. Randolph Pediatrics urges all patients to keep an active credit card on file with us, your card information will be kept confidential and secure.

BILLING POLICIES FOR RANDOLPH PEDIATRICS

- Balances requiring a second mailed statement will incur a $5.00 administration fee.
- Credit cards kept on file will automatically be charged for balances of $50.00 and under.
- If you carry a family balance at the time of an office visit, the balance must be paid that day.

CREDIT CARD ON FILE POLICIES

- Please complete the authorization form if you wish to keep a credit card on file.
- Return the form to the office via mail or the patient portal.
- Please indicate on the form if this is an HSA account card.
- Credit cards kept on file will be automatically charged for any copay, co-insurance, or deductible balances of $50.00 and under.
- You can authorize use of the credit card on file for balances above $50.00 by indicating the max amount allowed (i.e., $100.00). Otherwise please call the office to authorize payment.

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